MEDICATION CONSENT FORM

Child's Full Name _____

Date of Birth _____

Name of Medication _____

Duration of Medication _____

Dosage to be Given _____

Time(s) _____

Method of Delivery _____

Possible Side Effects _____

Reason for Use _____

Refrigeration Required **Yes** **No**

Physician's Name _____

Physician's Phone _____

Parent/Guardian Signature _____ **Date** _____

SAFETY CHECK FOR STAFF:

ALL PRESCRIPTION MEDICATIONS MUST BE IN THE ORIGINAL PHARMACY LABELED BOTTLE AND CAN ONLY BE ADMINISTERED IF THE ANSWERS TO ALL QUESTIONS BELOW ARE YES.

1. Is the consent form above complete?
2. Is the medication in a child resistant container?
3. Is the original prescription or manufacturer's label, including physician's directions for use, on the medication container?
4. Is the child's name on the medication?
5. Is the date on the prescription current?
6. Is the name and phone number of the physician who ordered the medication on the container?
7. Is the medication's name, dose and frequency of administration on the label consistent with parental instructions provided above?

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Date	Time	Dose	Reaction/Notes	Staff Signature